STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155747	A. BUII		-	12/11/	2012
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
454401					ERCER AVE		
ADAMS \	WOODCREST			DECATI	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'E	DATE
F000000							
			F00	0000			
	This visit was fo	or the Investigation of	100				
		_					
	Complaint numb	ber 1N00120027.					
	Complaint numb	per IN00120027					
	Substantiated. Fo	ederal / State deficiencies					
		egations are cited at					
	F157, and F282.	-					
	1137, and 1202.						
	Survey dates: December 10, and 11, 2012						
	Facility number:	000556					
	Provider number						
	AIM number:	100290130					
	Alivi number.	100290130					
	Survey Team:						
	Christine Fodrea	a, RN, TC					
	Census bed type	•					
	SNF/NF: 120						
	Total: 120						
	Census payor ty	pe:					
	Medicare: 17						
	Medicaid: 64						
	Other: 39						
	Total: 120	1					
	Sample: 3						
	These deficienci	ies reflect state findings					
		nce with 410 IAC 16.2.					
	once in accordan	100 WILLI TIO 1110 10.2.					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155747	B. WING		12/11/2012
NAME OF P	PROVIDER OR SUPPLIEF	· }	STREET .	ADDRESS, CITY, STATE, ZIP CODE	
		·		IERCER AVE	
ADAMS \	WOODCREST		DECAT	TUR, IN 46733	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 676Z11

Facility ID: 000556

If continuation sheet Page 2 of 10

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155747	B. WINC			12/11/	2012
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
ADAMON	MOODODECT				ERCER AVE		
ADAMS V	WOODCREST			DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000157	483.10(b)(11)						
SS=D	NOTIFY OF CHA	NGES					
	(INJURY/DECLIN	IE/ROOM, ETC)					
	A facility must imi	mediately inform the					
	resident; consult	with the resident's					
	physician; and if I	known, notify the resident's					
		ve or an interested family					
		ere is an accident involving					
		h results in injury and has					
		equiring physician					
		gnificant change in the					
		al, mental, or psychosocial					
	,	erioration in health, mental,					
	or psychosocial s threatening condi						
		need to alter treatment					
	•	a need to discontinue an					
		eatment due to adverse					
	•	r to commence a new form					
	-	a decision to transfer or					
		ident from the facility as					
	specified in §483.						
	,	(-).					
	The facility must a	also promptly notify the					
		nown, the resident's legal					
		interested family member					
	when there is a cl	hange in room or					
	roommate assign	ment as specified in					
	§483.15(e)(2); or	a change in resident rights					
	under Federal or	State law or regulations as					
	specified in parag	graph (b)(1) of this section.					
		record and periodically					
		ss and phone number of					
	_	al representative or					
	interested family		Fac	01.55			10/10/0010
		ew and record review the	F000	0157		_	12/12/2012
	facility failed to	ensure the physician and			F157 It is the policy of	f	
	family were noti	fied of changes to a			this provider to immediately		
	_	residents reviewed for			inform the resident, consult with	.n	
					the resident's physician, and		
	ianniy and pnysi	ician notification in a			notify the resident's legal		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 676Z11

Facility ID: 000556

If continuation sheet

Page 3 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLE	TED
		155747		LDING		12/11/2	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
A D A A 4 O 1	NOODODEOT				ERCER AVE		
ADAMS \	WOODCREST			DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sample of 3. (Re	esident #N)			representative of a significant		
	•	,			change in the resident's		
	Findings include	<u>.</u>			condition. The provider		
	I manigs include				respectfully requests IDR of th	is	
					alleged deficiency. Paper		
		cord was reviewed			compliance is requested. <u>1.</u>		
	12-11-12 at 10:0	98 AM. Resident N's			What corrective action will be accomplished for those reside		
	diagnoses includ	led but were not limited			found to have been affected b		
	to: Chronic airw	ay obstruction, diabetes,			the deficient practice: Resider		
	and edema.				#N's physician was notified of		
	una cacma.				change in the appearance of the		
	T., i	on 12-10-2012 at 7:20			stasis ulcer by his visit as		
					evidenced by his order written	for	
	· ·	N indicated the staff had			Keflex, an antibiotic and		
	told her leg wou	nd was improving, but			subsequent referral to an exte	rnal	
	did not tell her it	t had been getting worse			wound clinic for continued		
	until November.				treatment of the non-healing		
					stasis ulcer. The resident no	,	
	A ravious of the	nurse's noted dated			longer resides in the facility. 2 How other residents having the		
					potential to be affected by the		
		cated Resident #N had a			same alleged deficient practice		
		on the right leg. The			will be identified and what	_	
	wound measured	d 1.7 x 1.5. The note did			corrective action will be taken:		
	not indicate dept	th of the wound. The			Other residents with the		
	note further indi	cated the wound edges			propensity to be affected by th	e	
		ximated and there were			alleged deficient practice were	•	
		toms of infection.			identified as those with		
	ino sign or symp	ionis of infection.			non-healing stasis ulcers. 3 w		
	3.7	10 17 2012 : 1: 1:1			so identified. Each is seen by		
		10-17-2012 indicated the			external wound clinic (physicia		
		ments were now 1.6 x 1.5			to wit, no action is necessary the facility – the wound clinic	у	
	with yellow drai	nage. There was no note			contacts physician, family and		
	of physician, res	ident or resident			resident. 3. What measures		
		otification. The note did			be put into place or what syste		
	_	of measurement or depth			changes will be made to ensur		
	of the wound.	of measurement of deput			that the alleged deficient pract	ice_	
	oi uie wouliu.				does not recur: The weekly		
					Resident Care Committee will		
	A note on 10-22	-2012 indicated the area			review 3 charts of residents wi	ith	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		155747	B. WIN			12/11/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	ę.		1300 M	ERCER AVE		
	WOODCREST			DECAT	UR, IN 46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		.4 with a small amount of			stasis ulcers randomly selecte		
	yellow drainage.	. There was no indication			assess if a patient has a chang in stasis ulcer condition and	Je	
	the physician, re	sident, or resident			physician notification has		
	representative ha	ad been notified. The note			occurred within a professional		
	-	depth of the wound.			standard parameter. If it does	not,	
		•			corrective in-servicing will occi		
	A note on 10-27	-2012 indicated the area			A summary of these findings w	/ill	
		.5 x less than 0.1 The			be forwarded to the PI/QA&A Committee for review, monthly	for	
		cate unit of measurement.			3 months. <u>4. How the correct</u>		
					action will be monitored to ens		
		dication the physician,			the deficient practice will not re		
	•	lent representative had			i.e. what quality assurance		
	been notified.				program will be put into place:		
					The PI/QA&A Committee will		
	The wound had	been measured 11-11-12			review the summary from above	/e	
	when the notes i	ndicated the wound was			and make recommendations based on the summaries for		
	now 1.3 x 1.9 an	nd tender to touch. There			continued monitoring going		
	was no indicatio	n the physician, resident,			forward past 3 months. <u>5.</u>		
		sentative had been			Completion date: 12/12/12		
	notified.	Sentati ve nau seen					
	notified.						
	A physician's pr	ogress note dated					
		cated the physician had					
		a to be larger in size and					
		ysician ordered Keflex (an					
	antibiotic) to be	started.					
	A review of wor	and/skin care management					
		evealed measurements					
		il 9-17-2012. The facility					
	1 -	_					
	was unable to su	11.5					
		intil 11-1-2012. There					
		n of physician, resident or					
	1 -	ntative notification on the					
	forms.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 676Z11

Facility ID: 000556

If continuation sheet

Page 5 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2013 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER: 155747	A. BUILDING B. WING	<u>00</u>	COMPLETED 12/11/2012
	ROVIDER OR SUPPLIER WOODCREST	1300 MEF	dress, city, state, zip code RCER AVE R, IN 46733	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 12-11-12 at 11:20 AM, LPN #1 indicated Resident #N was notified about most of her care because she was alert and oriented, and the family was notified either by her or by the facility at Resident #N's request. She further indicated the physician should have been called when the area changed and immediately when it began draining. In an interview on 12-11-2012 at 1:32 PM, the Director of Nursing indicated the facility policy gave them 14 days after the change in a wound measurement to notify the physician. This Federal tag relates to complaint number IN00120027. 3.1-5(a)(3)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 676Z11

Facility ID: 000556

If continuation sheet

Page 6 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			12/11/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				ERCER AVE		
VDVM6 /	WOODCREST				UR, IN 46733		
ADAINS	WOODCREST			DECAT	UR, IN 40733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000282 SS=D	CARE PLAN The services provided facility must be propersons in accord written plan of car Based on intervieracility failed to outlined on the control of the	ew and record review the notify the physician as are plan for 1 of 3	F00	0282	It is the policy of this provider immediately notify/consult with the resident's physician as outlined in the care plan. The	l	12/12/2012
	residents reviewed notification accosmple of 3.	ed for physician rding to the care plan in a			provider respectfully requests of this alleged deficiency. Pap compliance is requested. <u>1.</u> What corrective action will be accomplished for those resides	IDR eer -	
	12-11-12 at 10:0 diagnoses includ	cord was reviewed 8 AM. Resident N's led but were not limited ay obstruction, diabetes,			found to have been affected by the deficient practice: Resider #N's physician was notified of change in the appearance of the stasis ulcer by his visit as evidenced by his order written Keflex, an antibiotic and subsequent referral to an extermound clinic for continued	the ne	
	10-12-2012 indice wound located or wound measured not indicate dept note further indice were well approximo sign or sympte. Nurse's notes on wound measurer.	nurse's noted dated cated Resident #N had a n the right leg. The 1.7 x 1.5. The note did h of the wound. The cated the wound edges ximated and there were soms of infection. 10-17-2012 indicated the nents were now 1.6 x 1.5 nage. There was no note ident or resident			treatment of the non-healing stasis ulcer. 2. How other residents having the potential be affected by the same allege deficient practice will be identified and what corrective action will taken: Other residents with the propensity to be affected by the alleged deficient practice were identified as those with non-healing stasis ulcers. 3 we so identified. Each is seen by a external wound clinic (physicial provider) to wit, no action is necessary by the facility – the wound clinic contacts physicial family and resident. 3. What	e <u>d</u> fied be e e e ere an	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 676Z11

Facility ID: 000556

If continuation sheet

Page 7 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPLET	TED
		155747		LDING		12/11/20	012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
A D A M O V	MOODODEOT				ERCER AVE		
ADAINS	WOODCREST			DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	representative n	otification. The note did			measures will be put into place		
	not indicate dep	th of the wound.			what systemic changes will be		
	•				made to ensure that the allege		
	Δ note on 10-22	2-2012 indicated the area			deficient practice does not rec	<u>ur:</u>	
		.4 with a small amount of			The weekly Resident Care Committee will review 3 charts	or	
					residents with stasis ulcers	, 01	
	l ·	There was no indication			randomly selected to assess if	fa	
		esident, or resident			patient has a change in stasis		
	representative h	ad been notified. The note			ulcer condition and physician		
	did not indicate	depth of the wound.			notification has occurred within	n a	
					professional standard parame	ter.	
	A note on 10-27	7-2012 indicated the area			If it does not, corrective		
		.5 x less than 0.1 The			in-servicing will occur. A		
		icate unit of measurement.			summary of these findings will forwarded to the PI/QA&A	be	
					Committee for review, for 3		
		dication the physician,			months. <u>4. How the corrective</u>	e I	
		dent representative had			action will be monitored to ens		
	been notified.				the deficient practice will not re		
					i.e. what quality assurance		
	The wound had	been measured 11-11-12			program will be put into place:	_	
	when the notes	indicated the wound was			The PI/QA&A Committee will		
		nd tender to touch. There			review the summary from abo	ve	
					and make recommendations		
		on the physician, resident,			based on the summaries for continued monitoring going		
	•	esentative had been			forward past 3 months. 5.		
	notified.				Completion date: 12/12/12		
	A physician's pr	ogress note dated					
	11-14-2012 indi	icated the physician had					
		ea to be larger in size and					
		ysician ordered Keflex (an					
	antibiotic) to be	•					
		started.					
		1/1:					
		und/skin care management					
		revealed measurements					
	every 5 days un	til 9-17-2012. The facility					
	was unable to su	apply further					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 676Z11

Facility ID: 000556

If continuation sheet Page 8 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155747	A. BUI	LDING	00	COMPL 12/11/	ETED
			B. WIN		DDDECC CITY CTATE 7ID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ERCER AVE		
ADAMS \	WOODCREST				UR, IN 46733		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ntil 11-1-2012. There					
	was no indication	n of physician, resident or					
	resident represen	tative notification on the					
	forms.						
	A care plan dated	d 3-15-2012 titled right					
	•	icated to observe for					
	signs of healing.	If the area was not					
	_	ement or signs of healing					
	U 1	notify the physician. for					
	•	treatment change.					
	potential fieed of	treatment change.					
	In an interview o	n 12-11-12 at 11:20 AM,					
		d Resident #N was					
		ost of her care because					
		l oriented, and the family					
		er by her or by the					
	_	nt #N's request. She					
		the physician should					
	have been called	as the care plan					
	indicated and wh	en the area changed and					
	immediately whe	en it began draining.					
	In an interview o	n 12-11-2012 at 1:32					
	PM, the Director	of Nursing indicated the					
		ve them 14 days after the					
		nd measurement to notify					
	the physician.						
	are priyoreium.						
	This Federal tag	relates to complaint					
	number IN00120	_					
	namoei mvotizo	1021.					
							'

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 676Z11

Facility ID: 000556

If continuation sheet

Page 9 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2013 FORM APPROVED OMB NO. 0938-0391

~		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/11/2012		
NAME OF PROVIDER OR SUPPLIER ADAMS WOODCREST				1300 M	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	I C	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 676Z11 Facility ID: 000556 If continuation sheet Page 10 of 10